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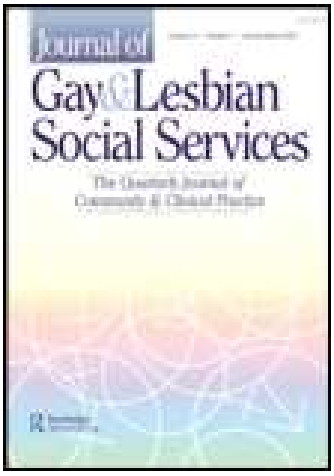

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Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) Perceptions and Health Care Experiences

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The goal of this study was to explore attitudes, health knowledge, and experiences with health care setting and providers among lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) individuals and to identify areas for improvement. Members of Equality Florida™ residing in the five counties of the Tampa Bay region were recruited through e-mail invitation to complete a 60-item questionnaire assessing demographics, attitudes, and experiences with health care providers (HCPs). Additional open-ended questions focused on experiences with HCPs and suggestions for ways to improve HCPs' cultural competency. A total of 632 respondents completed the survey of which 41% were gay men and 29% were lesbian. The majority of participants were White, non-Hispanic (93%), married/partnered (78%), and had health insurance (88%). The

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majority (67%) reported they always or often disclosed their sexual orientation/identity to an HCP and few had negative reactions in the health care setting (<10%). Health care settings with equality signs and gender-neutral language were perceived as safer. Participants' responses suggested need for policy changes and improved cultural competence among HCPs. Results show high rates of sexual orientation disclosure, greater acceptance from providers of LGBTQ status, and the need for examination of hospital policies and improved cultural competency.

KEYWORDS LGBTQ, health care policy, disclosure, disparities, cultural competency

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INTRODUCTION

The lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) community represents a growing and underserved population in the United States. LGBTQ include people of all races and ethnicities, all ages, all socioeconomic statuses, and from all parts of the United States (Ward, Dahlhamer, Galinsky, & Joestl, 2014; Palloni & Arias, 2004). Previous surveys have estimated that approximately 3.4% of the adult U.S. population (a random telephone interview sample of 121,290 adults, ages 18 and older, living in all 50 U.S. states and the District of Columbia) identify as LGBTQ (Gates, 2011; Gates & Newport, 2012). Compared to non-LGBTQ heterosexuals, previous studies have reported that LGBTQ tend to have attained less education, have lower incomes, and are less satisfied with their standard of living (Gates & Newport, 2012). In addition, health and utilization of health care services among LGBTQ individuals are still adversely affected by marginalization (Bjorkman & Malterud, 2009), and approximately 30% of LGBTQ adults do not seek out health care services or lack a regular health care provider (Winter, 2012). LGBTQ adults are also more likely to avoid or delay seeking health care compared to heterosexuals, resulting in delayed proper treatments and poorer health outcomes (Shields et al., 2012). Previous studies have reported highly prevalent risk factors and behaviors in the LGBTQ community including illegal drug use, alcohol use, smoking, obesity, and high prevalence of HIV/STDS, as well as mental health issues including depression, anxiety, eating disorders, and suicide (Cochran, Sullivan, & Mays, 2003; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Grella, Greenwell, Mays, & Cochran, 2009; Mollon, 2012; US Department of Health and Human Services: Center for Substance Abuse Treatment, 2012). These risk factors, combined with perceived access barriers to

health care, create a need for targeted and tailored health services for this community.

Despite the critical need for health care in the LGBTQ community, structural (e.g., cost, reduced access to health insurance, binary male/female medical record identification system) barriers to health care information and treatment significantly contribute to the avoidance or delay of seeking health care (Krehely, 2009; Roberts & Fantz, 2014). While the Affordable Care Act has introduced a ban on preexisting condition exclusions, improved coverage for screening and preventative care, and an option to filter for same-sex partner coverage, LGBTQ individuals continue to experience many barriers to health care access (The White House, 2013). Because of legal discrimination, financial barriers, and the unique health care needs of this population, LGBTQ individuals are less likely to have health insurance coverage for themselves and their partners than their heterosexual counterparts (Fredriksen-Goldsen et al., 2013; Krehely, 2009; Roberts & Fantz, 2014). Consequently, LGBTQ are less likely to be able to afford the costs associated with testing and screening for certain illnesses and are more likely to access emergency services and delay treatment until the condition becomes extremely difficult to treat or cure (Krehely, 2009). Furthermore, unique health care setting-related barriers to this population include fear of disclosing sexual orientation or gender, due to perceived discrimination, lack of health care professional knowledge and/or negative views of LGBTQ persons, and lack of sufficient access to culturally sensitive health care resources and referrals (Krehely, 2009). Some individuals choose not to disclose their sexual orientation or gender identity to health care providers as a logical decision, given the frequency of LGBTQ experience of negative attitudes, through both overt and covert forms of discrimination (Krehely, 2009; Roberts & Fantz, 2014). Many LGBTQ individuals report intense anxiety related to sexual orientation disclosure in health care settings, fearing that such disclosure will make them vulnerable to mistreatment and denial of care (Mollon, 2012; Roberts & Fantz, 2014; Stanton, 2013). Moreover, lack of health care provider knowledge of LGBTQ individuals' needs and the lack of LGBTQ resources and supportive environments result in less frequent health care-seeking behaviors (Krehely, 2009; Roberts & Fantz, 2014). Given the risk status of this community, removal of these barriers is imperative in order to improve the well-being of LGBTQ individuals.

Presently, there are limited data about the specific barriers in seeking health care in the LGBTQ population. This research is part of a larger study that will collect state and national data on the LGBTQ population; however, in the present study we created a Web-based questionnaire to survey an LGBTQ community in the Tampa Bay area about general experiences with health care providers and facilities, recent experiences related to hospitalization, and to provide opportunity for comments on areas in need of improvement. The Web-based questionnaire was derived from other

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published studies and validated instruments, with the addition of open-ended items that provided an opportunity for qualitative analysis in order to guide future research.

METHODS

Study Population

Members of Equality Florida™, including LGBTQ individuals and straight allies, residing in the five counties of the Tampa Bay region were recruited through an e-mail invitation. Equality Florida™ is a nonprofit advocacy group and the largest civil rights organization dedicated to securing full equality for Florida's LGBTQ community. Participants were part of the Equality Florida™ e-mail discussion list and resided in the geographic catchment area of the H. Lee Moffitt Cancer Center & Research Institute in Tampa, Florida, which includes the counties of Hillsborough, Pinellas, Pasco, Polk and Manatee. A total of 632 participants completed the survey and of those, 242 replied to a separate e-mail address to enter a gift card drawing. The investigators of this study did not have access to these e-mail addresses, which were monitored by a research assistant.

Participation was voluntary and anonymous. Participants received an e-mail invitation from Equality Florida™. The invitation included a link to the online survey. The e-mail was sent out three times between November 2013 and December 2013. Each e-mail blast was delivered using the Dillman Method (Dillman, 1978), which included three waves. The survey was available online from November 1, 2013, through January 1, 2014. Respondents were eligible to enter a drawing to receive a $100 Amazon.com gift card by providing an e-mail address to a separate website (not on the survey). A total of 35 gifts cards were distributed via a drawing of five cards weekly between November 8 and January 6.

Web-Based Survey

A 60-item Web-based survey was developed based on the Rainbow Health Initiative and "The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding" report from the Institute of Medicine (Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011; Rainbow Health Initiative, 2013). Survey items were categorized by demographics, knowledge, attitudes, and behaviors. The survey included branching that contained questions unique for the LGBTQ community members and for straight allies, as well as skip patterns to minimize respondent burden. In the opening set of items, there was an item for gender identity (male, female, transgender male to female [MTF], transgender female to male [FTM],

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other, prefer not to answer) and an item for sexual orientation (lesbian, gay, transgender MTF, transgender FTM, queer, questioning, straight, prefer not to answer).

Demographic data were collected, including age, ethnicity, race, relationship status, education level, employment status, and annual household income. Health care-related items assessed insurance status and health care surrogacy ("Do you have a health care surrogate?: yes, or something similar; no; prefer not to answer"). Knowledge of LGBTQ national health statistics was evaluated by providing choices for respondents to mark the most appropriate. Statements included respondents' awareness that members of the LGBTQ community are diagnosed with later-stage cancers due to: delay of treatment and/or lack of routine screening, exposure to serious medical conditions other than cancer, and the sparse amount of current research directed toward the LGBTQ community.

Attitudes were evaluated using questions regarding respondents' perceptions of their ability to disclose sexual orientation with health care providers, fear of the reaction of health care professionals toward LGBTQ status, reaction toward presence of LGBTQ equality sign in a health care setting, the impact of the word choices on health intake forms in relation to their views of the health care setting, cultural competency levels of health care providers regarding the LGBTQ community, and suggestions for needed changes or improvements they would like to see in the health care setting in terms of LGBTQ cultural competence (open-ended). Behaviors were evaluated with questions that asked about the respondent's disclosure of sexuality with health care professionals, involvement of allies in the care of LGBTQ patients, and whether or not the LGBTQ person had a health care surrogate.

Statistical Analyses

For quantitative measures, descriptive statistics were used to present the survey responses for gay men, lesbian women, bisexual men and women, and straight men and women (details discussed next). Group differences were explored using an appropriate parametric or non-parametric test statistic with $\alpha = .05$. The initial comparison included all four groups. Statistically significant differences were further explored with a series of paired comparisons (e.g., gay men versus lesbian women).

Qualitative Analyses

Qualitative responses from the open-ended questions were reviewed by three coders, hand-coded, and grouped for key themes based on the a priori content of the questions. Emergent themes were identified when participants reported similar thoughts about a topic that was not expressly asked about in

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TABLE 1 Frequency Distribution of Self-Reported Sexual Orientation and Gender Identity

	Gender Identity					
Sexual Orientation	Female	Male	Trans-gender: FTM	Trans-gender: MTF	Other	Total (%)
Gay	2	263	0	0	0	265 (41.9)
Lesbian	185	1	1	3	0	190 (30.1)
Straight	74	36	1	3	0	114 (18.0)
Bisexual	31	7	0	1	0	39 (6.2)
Queer	11	1	1	0	2	15 (2.4)
Prefer not to answer	3	1	0	0	1	5 (0.8)
Questioning	3	0	0	0	0	3 (0.5)
Transgender: MTF	0	0	0	1	0	1 (0.2)
Transgender: FTM	0	0	0	0	0	0 (0.0)
Total (%)	309 (48.9)	309 (48.9)	3 (0.5)	8 (1.3)	3 (0.5)	632

the survey. Content analysis was used to sort and thematically organize the open response comments. An inter-coder reliability rate of .95 was achieved in one round of coding.

RESULTS

Sexual Orientation and Gender Identity

Table 1 presents self-reported sexual orientation by gender identity among the 632 participants completing the survey. The most frequent sexual orientation was gay (41.9%), followed by lesbian (30.1%), straight (18%), bisexual (6.2%), queer (2.4%), and questioning (0.5%). There was one MTF transgender respondent (0.2%) and no FTM transgender respondents (0%). Fewer than 1% marked "prefer not to answer."

In terms of gender identity, there were equal percentages of females (48.9%) and males (48.9%), and a few MTF (0.5%) and FTM transgender respondents (1.3%). Because of too few transgender sexual orientation and gender identity respondents, these categories were not included in subsequent analyses. Data for four sexual orientation groups were analyzed: gay men ($N = 263$), lesbian women ($N = 158$), bisexual men and women ($N = 38$), and straight men and women ($N = 110$).

Demographic Information, General Health, and Health Care by Sexual Orientation

Table 2 presents demographics and health-related information by sexual orientation group. Group comparisons revealed significant differences for

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TABLE 2 Demographics and General Health Care by Sexual Orientation

	Sexual Orientation[a]			
	Gay (N = 263)	Lesbian (N = 185)	Bisexual (N = 38)	Straight (N = 110)
Male[b]	100.0	0.0	18.4	32.7
Age Group				
18 – 29 years	4.9	12.4	29.0	13.6
30 – 42 years	14.1	22.2	26.3	17.3
43 – 55 years	42.2	31.4	29.0	18.2
56 – 64 years	21.7	21.6	15.8	25.5
65 or more years	17.1	12.4	0.0	25.5
Race				
White	94.7	91.9	75.0	93.5
Black or African-American	1.9	4.4	8.3	3.7
Other	3.4	3.8	16.7	2.8
Hispanic Ethnicity	4.6	5.9	10.5	5.4
Married/Partnered	62.0	78.4	60.5	68.2
Education				
HS diploma/GED or less	7.3	6.5	5.4	7.3
Some college	16.8	15.7	27.0	24.6
Graduated college	38.6	35.1	37.8	32.7
Postgraduate degree	37.4	42.7	29.7	35.5
Employment Status				
Full-time	53.9	62.0	55.3	46.4
Part-time	9.2	7.1	13.2	10.0
Retired	23.5	13.0	2.6	26.4
Other	13.5	17.9	29.0	17.3
Median Household Income Category[c]	$70–79K	$60–69K	$40–49K	$50–59K
General Health and Health Care				
Insured	90.5	84.2	70.3	82.6
Have a health care surrogate	63.2	63.2	48.7	53.7
Surrogate is spouse or partner	74.6	82.8	66.7	70.7
Have received cancer diagnosis	17.7	14.7	10.5	14.6
Have received serious illness diagnosis	42.0	22.3	26.3	17.4

[a]Gay sexual orientation was restricted to males; lesbian sexual orientation was restricted to females; bisexual and straight sexual orientations were restricted to males and females.
[b]All values presented in table are percentages (%), except for household income.
[c]A total of 9.7% of participants marked "Prefer not to answer." Ns for the four Sexual Orientation groups were 21, 14, 4, and 19. For all other items providing this response option, less than 1.2% marked this option for a variable. Furthermore, no one participant marked this response to more than two items. "Prefer not to answer" was treated as missing data for all group comparisons.

several variables. For age group ($\chi^2(3) = 27.2$), bisexual men/women tended to be younger than the other groups (z's < –3.06) and lesbian women tended to be younger than gay men and straight men/women (z's < –2.19). For race ($\chi^2(6) = 20.3$), bisexual men/women were less likely to be White than the other groups ($\chi^2(2)$'s > 10.3). For relationship status ($\chi^2(3) = 14.5$), lesbian

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TABLE 3 Experience With Health Care Providers

	Sexual Orientation[a, b]		
	Gay (N = 263)	Lesbian (N = 185)	Bisexual (N = 38)
Disclosed Sexual Orientation[c]			
All providers	64.9	73.6	47.2
Some providers	29.0	22.5	30.6
None	6.2	3.9	22.2
Have Experienced Negative Reaction[c]			
Yes	11.9	10.5	14.7
Possibly	11.2	12.7	8.8
No	76.9	76.8	76.5
Fear Negative Reaction			
Always	3.8	4.3	2.6
Often	6.1	9.2	7.9
Sometimes	32.1	37.3	44.7
Rarely	22.5	22.7	29.0
Never	35.5	26.5	15.8

[a] Gay sexual orientation was restricted to males; lesbian sexual orientation was restricted to females; bisexual sexual orientation was restricted to males and females
[b] All values presented in table are percentages (%).
[c] Nine respondents reported not having a health care provider. "Prefer not to answer" was selected by one to three respondents for these three items.

women were more likely to be married/partnered than gay men or bisexual men/women ($\chi^2(1)$'s > 5.4).

For employment status ($\chi^2(9) = 24.4$), the distribution of employment categories differed for all groups except lesbian women and bisexual men/women ($\chi^2(3)$'s > 9.3). For annual household income ($\chi^2(3) = 15.2$), gay men and lesbian women reported higher income than did bisexual men/women and straight men/women (z's > 2.39). For health insurance ($\chi^2(3) = 13.4$), gay men were more likely to report having insurance than all other groups ($\chi^2(1) > 3.99$) and lesbian women were likely to report having insurance than bisexual men/women ($\chi^2(1) = 4.05$). For having been diagnosed with a serious medical illness ($\chi^2(3) = 31.3$), gay men were more likely to report this situation than lesbian women or straight men/women ($\chi^2(1) > 18.7$). The difference between gay men and bisexual men/women was marginally significant ($\chi^2(1) = 3.39$).

Experience With Health Care Providers by Sexual Orientation

Table 3 presents results for items concerning behaviors and feelings in relation to health care providers. These items were not administered to straight allies. There were significant differences among the three groups for

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disclosure and fear of negative reaction ($\chi^2(2)$'s > 6.8). Bisexual men/women were less likely to disclose sexual orientation than were gay men (z = –2.53), who were less likely to disclose than were lesbian women (z = –1.98). Gay men were less likely to report fearing a negative reaction from a health care provider than were lesbian women (z = 2.16). The difference between gay men and bisexual men/women was marginally significant (z = 1.95). There were no differences among the three groups in reported experience of a negative reaction from a health care provider.

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Equality Sign and Inclusive Language Terms by Sexual Orientation

Table 4 presents participants' perceptions of the use of the Human Rights Campaign (HRC) logo (Reibman & Liu, 2010; The Human Rights Campaign, 2014) and behaviors related to inclusive language terms. When asked about their feelings toward the presence of the Human Rights Campaign equality sign in health care settings, the majority of all groups felt more trust toward the setting. However, about 1 in 4 respondents reported they "have never seen the HRC equality sign." The only significant difference was observed for the "do not notice" response ($\chi^2(3) = 8.5$) where lesbian women marked this option less often than did bisexual men/women and straight men/women ($\chi^2(1)$'s > 4.5).

The majority of gay men, lesbian women, and bisexual men/women reported looking for "significant other or domestic partner" on medical intake forms. There were significant group differences ($\chi^2(2) = 24.1$) with lesbian women were more likely to mark yes than gay men and bisexual men and women ($\chi^2(1)$'s > 16.3). Furthermore, about 70% of respondents in all three groups stated that the setting was then viewed as more inclusive, although about 18% stated that this language has not been seen on an intake form.

Similarly, the majority of respondents in all three groups reported looking for gender-neutral language when referring to spouse/partner with significant group differences ($\chi^2(2) = 17.9$). Lesbian women were more likely to mark yes than gay men and bisexual men/women ($\chi^2(1)$'s > 7.9). About 60% in all three groups stated that the setting was then viewed as more inclusive when gender-neutral language was used, although about 18% stated that this language has not been seen on an intake form.

Cultural Competence

Nearly half of the participants ($N = 289$) provided open-ended comments on ways to improve LGBTQ cultural competence in a health care facility. First, participants indicated a need for respect, equal treatment, and overall inclusiveness. A participant summed up the thoughts of many through this

TABLE 4 HRC Symbol and Inclusive Language Terms by Sexual Orientation

	Sexual Orientation[a, b]			
	Gay (N = 263)	Lesbian (N = 185)	Bisexual (N = 38)	Straight[c] (N = 110)
When you see HRC "Equality" sign or other universal signs of acceptance[d]				
Feel more trust toward the setting	63.9	57.8	68.4	59.1
Feel it is safer to disclose	47.5	49.7	63.2	N/A
Does not make a difference	7.2	5.4	2.6	6.4
Am suspicious of the setting	1.5	0.5	0.0	2.7
Do not notice	5.3	2.7	13.2	8.2
Have never seen the HRC "Equality" sign	24.0	27.6	28.9	32.7
Do you look for the option of "significant other or domestic partner" on health intake forms?				
Yes	70.5	86.9	55.6	N/A
No	25.2	9.8	38.9	N/A
Don't know/Not sure	4.3	3.3	5.6	N/A
Seeing this option for marital status, how does it impact your perception of setting?				
View institution/setting as inclusive	69.1	73.5	73.0	N/A
Has no impact	14.5	6.5	2.7	N/A
Other	0.4	1.6	2.7	N/A
Have never seen this option	16.0	18.4	21.6	N/A
Do you look for gender-neutral language for partner on health intake forms?				
Yes	59.0	77.2	54.3	N/A
No	35.9	20.7	40.0	N/A
Don't know/Not sure	5.1	2.2	5.7	N/A
Seeing gender-neutral language, how does it impact your perception of setting?				
View institution/setting as inclusive	56.7	64.9	56.8	N/A
Has no impact	21.7	15.1	18.9	N/A
Other	1.5	1.1	8.1	N/A
Have never seen this option	20.1	18.9	16.2	N/A

[a]Gay sexual orientation was restricted to males; lesbian sexual orientation was restricted to females; bisexual and straight sexual orientations were restricted to males and females.
[b]All values presented in table are percentages (%). Those marking "N/A" (e.g., have not completed a medical form) or "prefer not to answer" were coded as missing.
[c]N/A represents those items/responses for straight respondents that were not applicable (i.e., not asked or not given the response option).
[d]Participants were permitted to check each of the six response options. Group comparisons were completed for each response option.

suggestion: "The golden rule. Treat others as you want to be treated." Participants also suggested a need for staff training to improve knowledge and sensitivity: "Sensitivity would encourage nervous patients to be more honest" and "Improved nondiscrimination training for all levels of staffing, including

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service staff." Participants wanted more partner involvement and visitation rights in the health care setting: "Accept my word or that of my partner... that my partner is allowed to see me ANYTIME. Straight people DO NOT need documentation, why should we?" and "Health care providers should be more inclusive of spouse/significant other in discussing patient's condition." Participants also felt that there was a need for improvement of health intake forms: "Universal inclusive language on forms and staff training so they are not surprised and act surprised" and "I would like hospitals to ask for both gender and sexual orientation on intake forms." In addition to these changes in forms, participants suggested that health care providers/facilities could create a welcoming environment with visible LGBTQ stickers and signs: "Maybe have some sort of recognition or acknowledgment of GLBTQ people, even a HRC [Human Rights Campaign] equality sticker that only 'we' know about" and "I really like the idea of safe zone/LGBT friendly signage ... assuming it's done in a way that feels legitimate." Finally, multiple lesbian respondents noted the requirement of a pregnancy test by medical institutions, particularly after they had disclosed their sexual orientation was "a slap in the face" or was taken as an indication the health care provider "was not listening to me" or "collecting information but not tailoring my care to my needs."

DISCUSSION

Using a Web-based questionnaire, this analysis assessed LGBTQ attitudes, knowledge, and experiences of general health care by sexual orientation. The results indicated that more participants reported having health care insurance, greater incidences of disclosure, greater acceptance from providers of LGBTQ status, and more positive and less negative experiences with health care providers than previous studies (Bjorkman & Malterud, 2009; Boehmer, Miao, & Ozonoff, 2011; Durso & Meyer, 2013; Eliason & Schope, 2001). Our results suggest the LGBTQ community is becoming more recognized and accepted in the health care system. Furthermore, disclosure is widely regarded as having a positive impact on LGBTQ individuals' health. In previous studies, many lesbian women chose to disclose their sexual orientation in an effort to build open and trusting relationships with health providers (Austin, 2013). Other studies have suggested that disclosure results in greater satisfaction with health care providers as well as more routine receipt of preventive screenings (Austin, 2013), and that non-disclosure is associated with poorer psychological well-being (Durso & Meyer, 2013). Thus, studies disseminating the positive aspects of disclosure and highlighting limited numbers of negative experiences may encourage members of the LGBTQ community to share this personal information with a health care provider.

Under the umbrella term of LGBTQ, each group has unique and specific health care needs associated with self-identified gender and sexual

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orientation. For example, lesbian and bisexual women have specific needs in areas of sexual and cervical health, reproductive health and parenting, mental health, substance use, and aging (McNair, 2003). However, they are less likely to seek health care providers and more likely to delay seeking routine care such as Pap tests, breast exams, cervical cancer screenings, and mammograms (Fredriksen-Goldsen et al., 2013). Gay men also use health services less frequently than their heterosexual counterparts (Fish & Anthony, 2005; Heck, Sell, & Gorin, 2006). Specifically, gay men are less likely to inquire about or receive a prostate screen compared to heterosexual men (Fredriksen-Goldsen et al., 2013). The need for preventive and mental health care in these populations has been documented but less is known about barriers to access of these services. Future studies in our research group will focus on these key issues.

Due in part to the additional risk factors associated with this community, LGBTQ populations also face an increased risk of some cancers, which may go unrecognized by the individual and by the physician (Johnson, Madeleine, Newcomer, Schwartz, & Daling, 2004; Lee, 2000; Mayer et al., 2008). In addition, lesbian women are more likely to report having cervical and uterine cancer and gay men are twice as likely to receive a late-stage cancer diagnosis compared to heterosexual males (Boehmer et al., 2011). Moreover, LGBTQ cancer survivors are more likely to report fair or poor health compared to heterosexual cancer survivors (Boehmer et al., 2011). The needs and desires of LGBTQ patients with terminal cancer are not fundamentally different from any other individuals' needs. However, for LGBTQ cancer patients, the usual challenges of diagnosis and treatment are further complicated by the need to disclose sexual orientation, which may be difficult based on previous negative health care experiences (Katz, 2011). While our study found fewer negative health care experiences than reported by other authors, our results still highlight the need for policy and practice changes, like increasing cultural competence and posting welcoming signage, which will continue to improve the health care experience for the LGBTQ population.

Social stigma and insensitivity related to LGBTQ issues are stressors with profound mental health consequences, resulting in low self-esteem, suicidal ideation, depression, anxiety, substance abuse, tobacco use, and feelings of powerlessness and despair (Johnson, Mimiaga, & Bradford, 2008). Consequently, providing a safe and welcoming environment in health care facilities is imperative to increasing screening and treatment-seeking behaviors in the LGBTQ and other minority populations (Brach & Fraser, 2000; Hutchinson, Thompson, & Cederbaum, 2006). A statistically significant number of participants reported they felt more trust and safer to disclose information when there were visible equality signs and symbols throughout the hospital. Furthermore, they looked for gender-neutral language and symbols on forms to increase this sense of security and influence their view of the institution and setting as inclusive. The appropriate usage of language and symbols is

essential for this population, whose past history of stigmatization and discrimination has made these individuals feel unsafe and oppressed (Sardar, 2008).

Because of the barriers the LGBTQ community faces in seeking health care, it was essential to learn how to facilitate care and improve their experiences within health care settings and with health care providers. Participants' comments on ways to improve LGBTQ cultural competence at any health care facility indicated a great need for additional staff training to improve LGBTQ knowledge, a sense of overall inclusiveness from health care staff, culturally sensitive health care forms, and a welcoming health care environment. These findings are in line with common opinions and needs from this community (Lee, 2000; Mayer et al., 2008; Roberts & Fantz, 2014).

Risk factors such as smoking, excessive alcohol use, and risky sexual behaviors may place LGBTQ individuals at higher risk for developing certain cancers. Participants reported higher incidences of cancer diagnoses than previous studies involving lesbians, bisexual males and females, and gay men (Boehmer et al., 2011). Increased incidence of cancer diagnoses in this population indicate an essential need to prevent future cancers through routine screens and increased accessibility to cancer care facilities and treatment. For LGBTQ individuals with terminal cancer, legal restrictions and societal attitudes can negatively affect their dying experiences. Lesbians and gay men face many challenges, including issues of disclosure in the health care setting, discrimination, misconceptions, legal and financial barriers, and the disenfranchised grief of surviving same-sex partners (Smolinski & Colón, 2006). If these challenges are not resolved through legal and social means, the health care disparities evident in the LGBTQ community will continue to worsen.

LIMITATIONS

This study has several limitations. We did not use a random sampling strategy to collect these data. There were very few bi-gender and transgender individuals in the sample. Also, data were collected in one geographic area in Florida and participants' demographic information and views may not represent those of other areas of the United States. We partnered with Equality Florida™, a statewide advocacy group for LGBTQ persons and their allies, because they have the largest population of supporters in the Tampa Bay region. While our study population is highly representative of the known LGBTQ population of the counties of Florida where the study was conducted, LGBTQ individuals who are not members of Equality Florida™ or who do not identify with this community did not have access to the survey and are therefore not represented.

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CONCLUSIONS

Health care providers have a vital role in promoting awareness of LGBTQ health issues and inequalities through education, research, and health policy (McNair, 2003). Health care providers' attitudes are vital to the care of LGBTQ individuals, as they can affect their ability to provide appropriate care to this community. LGBTQ individuals' experience of health care disparities can be eliminated if clinicians elicit information about sexual orientation and gender identity and provide a nonjudgmental and empathetic environment (Makadon, 2012). Medical institutions, physicians, nurse educators, practitioners, and policymakers all have critical roles to play in the accessibility of health care and cancer care for LGBTQ individuals. Future studies that include larger numbers of individuals across broader geographic areas are needed to understand the health care needs and barriers of LGBTQ individuals.

As a result of this study, our local health care institution is changing medical intake forms to include additional gender identity options and sexual orientation. In addition, we will review clinical guidelines and hospital policies to explore a provision of explanation for why pregnancy tests are required of all females or discontinue requiring these tests for women who report their sexual orientation as lesbian and do not consider pregnancy a possibility. Other important policy issues include hospital visitation and end-of-life decision making. Hospital visitation policies may not recognize same-sex partners and these partners may be unable to enforce directives regarding health and hospice care. We also recommend improvements to confidentiality of disclosure, particularly for transgender individuals.

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